Confidential Patient Record

Personal Health History

Date	Pt #

Name_____________________________________ Address ____

City _______________________________________ State _________________ Zip ______________

Primary contact #:_____________________ Cell ____ Home____ Alternative phone # ___________________ Cell ____ Home____

Preferred contact for appointment confirmation Text____ Call ____Email_________________________________

Date of Birth __________________________ Age _____ Sex: Male ____ Female ____

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Referred to this office by ____

Employer_______________________________________Occupation____________________________________

Spouse's Name _________________________ Spouse's Date of Birth _________________ No. of Children ____

Spouse's Employer _________________________________ Spouse's Occupation, _______________________

Emergency Contact ____ Phone Number _____________________

If you are interested in receiving up-to-date natural health tips, seminar dates, recipes, etc. by email, please

provide your email address: ____

May we email you 1 time to remind you of upcoming seminar, if you have not yet attended Yes___ No____

The party responsible for this bill must provide his/her date of birth:

Name __________________________________ Date of Birth _______________

Phone # where-insured can be reached ______________________ Best time to-reach them________________

CURRENT HEALTH CONDITION

Main health concern which brought you to this office ____

Other doctors you have seen for this condition ____

Type of treatment ________________________________ Results _____________________________________

Please list all drugs (prescription or over the counter) including antacids, aspirin, or anything else that you are taking, and the purpose of the drug:

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List Allergies

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PLEASE PRESENT YOUR INSURANCE CARD AND DRIVERS LICENSE TO STAFF MEMBER WHEN TURNING IN THIS FORM